Patient Management Module

Skin Test

# SKIN TEST

| (Last, First,, Middle) CLIENT NAME: | | DATE OF BIRTH: / / | Age: |
|---|---|---|---|
| SS #: | STATE CASE #: | CITY/COUNTY CASE #: | |
| SITE: | SPECIAL ATTENTION REQUIRED: Explain | | |

**Type of Test** (Check one)
G Tuberculin G Tetanus G Candida G Mumps

**Date Tested**: _____/_____/_____ **By**: (name) _____

**Date Read**: _____/_____/_____ **By**: (name)_____

**Induration (mm)**: _____ **Results**: (Check one) G Positive G Negative G Unknown

**Comments**: *(CAN be entered into TIMS)*_____

**Is the Patient Anergic** (Check one)
G Yes G No G Unknown

**Does the Patient meet the CDC Criteria for being classified as a Converter** (Check one)
G Yes G No G Unknown

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**Does the Patient meet the CDC Criteria for being classified as a Converter** (Check one)
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User Defined Variable Information (If needed)

_____ ____/_____/____
Completed By Date